MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2004

Rocky Mountain HealthCare Options, Inc.
2775 Crossroads Blvd.
Grand Junction, Colorado 81506

NAIC Group Code 1184
NAIC Company Code 47004

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

Rocky Mountain HealthCare Options, Inc.
2775 Crossroads Blvd.
Grand Junction, Colorado 81506

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2004

Examination Performed by

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

John E. Bell

David M. Tucker, AIE, FLMI, ACS

Amy N. Gabert

Paula M. Sisneros, AIS

Colorado Market Conduct Examiners

March 24, 2006

The Honorable David Rivera
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Rocky Mountain HealthCare Options, Inc. (the Company) was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, Colorado Revised Statutes, which authorize the Insurance Commissioner to examine nonprofit hospital, medical-surgical health service corporations. We examined the Company's records at its principal office located at 2775 Crossroads Blvd., Grand Junction, Colorado, 81506 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2004, through December 31, 2004.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

John E. Bell

David M. Tucker, AIE, FLMI, ACS

Amy N. Gabert

Paula M. Sisneros, AIS

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The Company provided the following narrative:

COMPANY PROFILE

Rocky Mountain HealthCare Options, Inc. (Rocky Mountain HealthCare Options) is a Colorado nonprofit corporation that has a certificate of authority to operate as a nonprofit hospital, medical-surgical health service corporation. Rocky Mountain Health Maintenance Organization is the sole member of Rocky Mountain HealthCare Options. Rocky Mountain HealthCare Options obtained its certificate of authority and began operations in May 28, 1993.

Rocky Mountain HealthCare Options provides medical benefit plans and services to more than 33,000 commercial members. The organization offers a wide range of medical benefit options including PPO large and small group plans, individual plans and high deductible health benefit plans for health savings accounts (HSAs). Through its offerings Rocky Mountain HealthCare Options serves a broad cross section of Coloradoans.

OPERATIONS

Rocky Mountain HealthCare Options operates only in Colorado. The company is authorized by the Colorado Division of insurance to operate in all counties in the state of Colorado. The company's headquarters is located in Grand Junction, Colorado. Rocky Mountain HealthCare Options provides local, community based care and has branch offices throughout Colorado including Denver, Pueblo and Durango. A map defining the company's territory is attached. Accounting records are maintained in the corporate offices in Grand Junction, Colorado.

Rocky Mountain HealthCare Options provides healthcare benefits to large and small employer groups and individuals. The company contracts with individual physicians, physician groups and physician practice association, hospitals and the health care providers to provide health care services to its members. In Western Colorado, more than 90 percent of the physicians in most service areas participate with Rocky Mountain HealthCare Options. Nearly every hospital in the Western Slope service area participates. Statewide, Rocky Mountain Health plans contracts with approximately 5,000 primary care and specialty care physicians and 240 hospitals, rehabilitation centers and skilled nursing facilities.

Individual Enrollment As of 12/31/2004 :	3,930
Small Group Enrollment as of 12/31/2004:	19,952
Large Group Enrollment as of 12/31/2004:	5,260
Individual Written Premium as of 12/31/2004:	5,390,533
Small Group Written Premium as of 12/31/2004:	46,259,518
Large Group Written Premium as of 12/31/2004:	14,484,489
Market Share (all Colorado Accident and Health Insurance):	.92%

The NAIC Group code for Rocky Mountain HealthCare Options is 1184 and the NAIC company number is 47004.

ROCKY MOUNTAIN HEALTHCARE OPTIONS FINANCIAL STABILITY

As of December 2004, the organization's reserves were approximately $6 million on 2004 revenues of approximately $ 66 million.

ORGANIZATION STRUCTURE

Rocky Mountain HealthCare Options is a Colorado nonprofit corporation. The organization has a certificate of authority from the Colorado Division of Insurance to operate as a nonprofit hospital, medical-surgical health service corporation. Rocky Mountain HealthCare Options began operations in May 1993. A community Board of Directors selected by Rocky Mountain HMO directs the company's operations. Rocky Mountain HMO, a health maintenance organization, is the sole member of Rocky Mountain HealthCare Options.

A relational organization chart is attached. An organizational chart detailing the levels of management and reporting structure is also attached.

COMPANY OPERATIONS & MANAGEMENT

Rocky Mountain Health Maintenance Organization, Inc. – Colorado Non-profit Organization – FEIN 84-0614905 – NAIC Code 95482 – State of Domicile – CO

Rocky Mountain HealthCare Options, Inc. – Colorado non-profit hospital, medical/surgical and health service corporation – FEIN 84-1224718 – NAIC Code 47004 – State of Domicile – CO

(Rocky Mountain Health Maintenance Organization, Inc. is the only member of Rocky Mountain HealthCare Options, Inc.)

CNIC Health Solutions, Inc. – Colorado Corporation – FEIN 71-0873411

(Rocky Mountain Health Maintenance Organization, Inc. owns 100% of the outstanding stock of CNIC Health Solutions, Inc.)

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204, 10-1-205(8) and 10-3-1106, C.R.S., which empowers the Commissioner to examine any entity engaged in the insurance business including hospital service plans, reviewed certain business practices of Rocky Mountain HealthCare options, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to hospital, medical-surgical and health service corporations. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2004, through December 31, 2004.

The examination included review of the following:

Company Operations and Management
Underwriting: Applications, Forms, Rates and Cancellations/Declinations
Utilization Review
Claim Handling

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms permit the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to small and large group health insurance reform laws as they pertained to hospital, medical-surgical and health service corporations. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any hospital, medical-surgical and health service corporations.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations. For this examination, special emphasis was given to small group reform, and the laws and regulations as shown in Exhibit 1.

During the exam, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain HealthCare Options, Inc. and Rocky Mountain Health Maintenance Organization, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies.

Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1101-10-3-1104	Unfair Competition – Deceptive Practices
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title – Definitions – General Provisions
Section 10-16-106.5	Prompt Payment of Claims
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-302-10-16-319	Non-profit Hospital, Medical-surgical, and Health Service Corporations
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-4	Maintenance of Offices in this State
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-1-8	Penalties and Timelines Concerning Division Inquires and Document Requests
Regulation 4-2-3	Sickness and Accident Insurance Advertising
Regulation 4-2-5	Hospital Definition
Regulation 4-2-8	Required Health Insurance Benefits for Home Health Services and Hospice Care
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-17	Prompt Investigation Health Plan Claims Involving Utilization Review
Regulation 4-2-18	Concerning to Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-2-19	Concerning Individual Health Benefit Plans Issue to Self-employed Business Groups of One
Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-7	Concerning Premium Rate Setting for Small Group Plans
Regulation 4-6-8	Concerning Small Employer Health Plans
Regulation 4-6-9	Conversion Coverage

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous market conduct exam in 2000, which covered the period January 1, 1999 through December 31, 1999. The Company also underwent financial examinations by the Colorado Division of Insurance which covered the periods ending in December of 1995 and December 0f 1999.

Contract Forms

The examiners reviewed the following forms:

- The Company's Basic and Standard PPO Plans, Co-payment Schedules and Schedule of Benefits;
- The Company's most commonly sold PPO group contracts marketed to small employers and business groups of one;
- The Company's PPO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee PPO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2004 and December 31, 2004.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the Underwriting (new applications) section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Applications

For the period January 1, 2004 through December 31, 2004, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group new application files; and
- Fifty (50) individual new application files.

Cancellations/Terminations/Declinations

For the period January 1, 2004 through December 31, 2004, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Fifty (50) small group cancelled/terminated files; and
- Fifty (50) declined small group files.
- Fifty (50) cancelled/terminated individual files.
- Fifty (50) declined individual files.

Claims

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain HealthCare Options, Inc. and Rocky Mountain Health Maintenance Organization, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies. Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies. Accordingly, the claims review portion of the Rocky Mountain Health Maintenance Organization, Inc. examination report is "deemed" to apply to Rocky Mountain HealthCare Options, Inc.

In order to determine the Company's compliance with Colorado's prompt payment of claims law, the examiners reviewed the following random samples:

- 100 electronic claims paid or denied beyond thirty (30) days; and
- 100 non-electronic claims paid or denied beyond forty-five (45) days; and
- 50 claims paid or denied beyond ninety (90) days.

In addition, the examiners identified 289 claims out of a population of 64,501 denied and 4,527 claims out of a population of 380,951 paid small and large group claims that were not paid, or settled within ninety (90) days after receipt. These claims were reviewed to determine if they had been delayed due to fraud, and if not, if interest and penalties had been paid. The claims review portion of the Rocky Mountain Health Maintenance Organization, Inc,. examination report is "deemed" to apply to Rocky Mountain HealthCare Options, Inc.

Utilization Review

During the examination, the examiners met with the Company examination coordinator to discuss the examination process. One of the topics discussed was that although Rocky Mountain HealthCare Options, Inc. and Rocky Mountain Health Maintenance Organization, Inc. are separate companies, there are many policies, procedures and forms that are common to both companies. Therefore, it was agreed that in those cases where it appeared that a comment form may be applicable to both companies, the examiners would include an option for the Company to "deem" the findings to be applicable to both companies, even though the actual findings may have been identified in only one of the companies. Accordingly, the utilization review portion of the Rocky Mountain Health Maintenance Organization, Inc. examination report is "deemed" to apply to Rocky Mountain HealthCare Options, Inc.

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed the entire population of thirty-nine (39) first level appeal files, the entire population of three (3) second level appeal files, the entire population of one (1) external review file and the entire population of twenty-eight (28) reconsideration files.

In addition, the examiners selected a sample of fifty (50) utilization review (UR) denial decision files from a summarized population of 96. The examiners also selected a sample of 100 utilization review (UR) certification decisions from a summarized population of 5,609. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty (20) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Operations/Management: There were no areas of concern identified in the review of the Company's operations/management.

Contract Forms: The examiners identified nine (9) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

- Failure of the Company, in some cases, to limit the look-back period in its forms, for questions related to health information, to the maximum five (5) year period.
- Failure of the Company's forms, in some cases, to correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee.
- Failure of the Company's forms to include only appropriate questions in its form used for determining whether someone qualifies as a disabled dependent.
- Failure of the Company's forms to provide accurate information regarding the rights of members to contact the Colorado Division of Insurance on any and all matters of concern.
- Failure of the Company's forms to limit exclusions for expenses related to the AIDS illness to the same extent as other covered illnesses and conditions.
- Failure of the Company to properly title its Basic and Standard Health Benefit Contracts.
- The Company utilizes forms which inequitably represent that it is solely responsible for determining if medical services and/or treatments are experimental in nature.
- Failure, in some instances, to file and certify a new policy form in accordance with Colorado insurance law.
- Failure of the Company to properly describe the home health care and hospice care services in accordance with Colorado insurance law.

New Business: The examiners identified one (1) areas of concern in their review of small group contracts issued between January 1, 2004 and December 31, 2004.

- Failure to obtain the required employer listing of eligible dependents.

Cancellations/Non-Renewals/Declinations: There were two (2) areas of concern identified during the review of the small group and individual cancellation/non-renewal/declination files.

- Failure, in some cases, to issue certificates of creditable coverage that reflect the definition of "Significant break in coverage."

- Failure to use policies and procedures in individual plan cancellations which do not permit unfair discrimination.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company. (Note: All four (4) issues were deemed from the findings of Rocky Mountain Health Maintenance Organization examination) Issues arise from Colorado insurance law requirements dealing with the fair and equitable settlement of claims, claims handling practices and the timeliness and accuracy of claim payments. The issues in this phase are identified as follows:

- Failure, in some instances, to pay, deny, or settle claims within the time frames required by law.

- Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by law.

- Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.

- Failure to use claim payment procedures that do not result in unnecessary delays.

Utilization Review: The examiners identified four (4) areas of concern in their review of the Company's Utilization Review procedures. (Note: All five (5) issues were deemed from the findings of Rocky Mountain Health Maintenance Organization examination)

- Failure, in some instances, to include all required elements in written notification letters sent to members and providers regarding appeals.

- Failure, in some instances, to make utilization review approval determinations or to notify the member and provider of the determination in the manner and time frame allowed by Colorado insurance law.

- Failure, in some instances, to provide written notification of adverse utilization review denials or to provide the notifications within the time frames required by Colorado insurance law.

- Failure, in some instances, to include all required elements in written notifications of utilization review denials sent to members and providers.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance. Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

ROCKY MOUNTAIN HEALTHCARE OPTIONS, INC.

UNDERWRITING CONTRACT FORM FINDINGS

Issue E1: Failure of the Company, in some cases, to limit the look-back period in its forms, for questions related to health information, to the maximum five (5) year period.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states in part:

> (7) *An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to this section shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years before the date of application.* [Emphasis added.] Medical information that is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or from using such information on current health status to underwrite or set premiums for the group as provided by law.

It appears that the Company is not in compliance with Colorado insurance law in that the forms require individual enrollees of small employer groups to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period on application forms. The Company's certification of handicapped dependents form also requests medical information without limiting the time period for that information to the maximum five (5) year limit.

The Company's application and enrollment forms state the following:

> 2. We understand and acknowledge that RMHMO and RMHCO or their designated agents/contractors may obtain, use, and disclose information or medical records related to the health of any person proposed for coverage for the treatment, payment, and health care operations functions of RMHMO or RMHCO. For example, these treatment, payment, and health care operation functions of RMHMO or RMHCO include use of such information for processing and payment of claims, in RMHMO or RMHCO quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may be obtained from any physician, health care provider, hospital, clinic, other medical facility insurance company, or other entity. All information is subject to confidentiality laws. *I authorize any physician, health care provider, hospital or other medical facility, insurance company, or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage to give the health plan such information and supplement such information as requested.* [Emphasis added.]

The Company's Certification for Handicapped Dependents states in part:

> Was your Dependent ever institutionalized? Yes No
> If yes, give name and address of institution(s):
> _____
> _____
> _____
> Period confined: From: _____ To: _____

Section II — Must be Completed by Primary Care Physician
Is Dependent presently incapable of self-sustaining employment by reason of:
Physical Handicap _____ (circle one) Permanent /Temporary
Mental Handicap _____(circle one) Permanent /Temporary
Is incapacity congenital? Yes No
Diagnosis of condition causing handicapped status:

Form	Form Number
Enrollment Form – Group Coverage	MK235R1004
Application for Conversion Coverage	MK181R1004
Request for Coverage For a Physically or Mentally Handicapped Dependent Child	MS35R0403

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why its forms should not be considered in violation of Sections 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to ensure that questions related to health status include a maximum five (5) year look-back period as required by Colorado insurance law.

Issue E2: Failure of the Company's forms, in some cases, to correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee.

Section 10-16-102, C.R.S., Definitions, states in part:

(26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual:

(I) Was covered under other creditable coverage at the time of the initial enrollment period and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;

(II) Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or employer contributions towards such coverage was terminated; and

(III)Requests enrollment within thirty days after termination of the other creditable coverage; or

(b) The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;

(c) A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or

(d) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment no later than thirty days after becoming such a dependent. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

It appears that the Company's forms are incomplete and potentially misleading in that neither the business group of one application form, nor the standard enrollment form, correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period. The Company' forms allow for coverage within thirty (30) days of marriage, birth, adoption, or placement for adoption but fail to also allow for enrollment in the case of loss of creditable coverage on the Business Group of One application, and and loss of creditable coverage and court ordered coverage are not included on the Group Coverage Enrollment Form and the Employee/Dependent Waiver forms.

The Company's "Enrollment Form – Group Coverage" and "Employee/Dependent Waiver", state the following:

> 6. I understand that if I decline coverage for myself or my dependents (including my spouse)
>
> because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends. *I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.* I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I can't enroll this dependent until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage*. I also understand that, upon enrollment, I and/or my dependent(s) may be subject to a pre-existing condition limitation period.* [Emphases added.]

The Company's "Application – Business Group of One" form, states in part:

> 6. I understand that if I decline coverage for myself or my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends. *I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.* [Emphasis added.] I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I can't enroll this dependent until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that, upon enrollment, my dependent(s) may be subject to a pre-existing condition limitation period. I further understand that if my dependent(s) (other than a newborn, adopted child, child places for adoption, or child subject to a court order for health care coverage) were not medically underwritten at the time I initially enrolled in this plan, then my dependent(s) must pass medical underwriting to enroll in any plan subject to the above requirements, except that no medical screening will be required to enroll in an RMHMO or RMHCO PPO Basic Health Benefit Plan Without Specified Mandates or Standard Health Benefit Plan for Colorado.

Form	Form Number
Application – Business Group of One	MK100R1104
Enrollment Form – Group Coverage	MK235R1004
Employee/Dependent Waiver	MK105R1004

Recommendation No. 2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to correctly define any instances that would qualify dependents to enroll after the initial open enrollment period as required by Colorado insurance law.

Issue E3: Failure of the Company to include only appropriate questions in its form used for determining whether someone qualifies as a disabled dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and *an unmarried child of any age who is medically certified as disabled and dependent upon the parent.*[Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its "Request for Coverage For a Physically or Mentally Handicapped Dependent Child" form is too restrictive. Colorado insurance law only requires that the dependent be medically certified as disabled, but the Company's form asks questions that seem to imply that it has a more stringent standard for determining who qualifies as a disabled dependent. Specifically, Colorado law does not use employment status, degree of disability, or type of disability in determining whether someone qualifies as a disabled dependent.

The Company's Certification for Handicapped Dependents states the following:

Section I — To be Completed by Subscriber

Date of Disability: _____ /_____/_____
Month Day Year
Was your Dependent ever institutionalized? Yes No
If yes, give name and address of institution(s):
Period confined: From: _____To:_____
Is your Dependent eligible for care under federal, state or local law? Yes No
If yes, give details:
Was, or is, your Dependent employed for wages? Yes No
If yes, give details:
Average weekly earnings: $ _____

Section II — Must be Completed by Primary Care Physician

Is Dependent presently incapable of self-sustaining employment by reason of:
Physical Handicap _____ (circle one) Permanent /Temporary
Mental Handicap _____(circle one) Permanent /Temporary
Is incapacity congenital? Yes No
Diagnosis of condition causing handicapped status:

Form	Form Number
Request for Coverage For a Physically or Mentally Handicapped Dependent Child	MS35R0403

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certification of handicapped dependent form to only include questions directly related to the dependent's disability and dependence on the parent as required by Colorado insurance law.

Issue E4: Failure of the Company's forms to provide accurate information regarding the rights of members to contact the Colorado Division of Insurance on any and all matters of concern.

Section 10-16-316, C.R.S., Complaints, states:

> Any individual subscriber of a corporation subject to the provisions of part 1 of this article and this part 3 who is aggrieved by any act or omission of such corporation or its officers, directors, agents, or representatives, may file a statement in writing of such grievance in the office of the commissioner and the commissioner may make such investigation of such grievance as the commissioner deems appropriate. No such investigation by the commissioner shall act as a bar to any suit in a court of competent jurisdiction instituted by any such member or subscriber, or any defense thereto by the corporation involved.

The Company's Health Benefits Contract states the following:

10. MANDATORY COMPLAINT PROCEDURES

H. Referral to Insurance Commissioner:

> Any complaint, controversy, dispute or disagreement *as to whether any health care service is a Benefit covered under the provisions of this Contract* may be referred to the Insurance Commissioner of the State of Colorado. [Emphasis added.]

Form	Form Number
HCO Solo Health Benefit Contract for Colorado	HCO-2004-SOLO-I-HBC-01-104
PPO Basic Health Benefit Plan without Specified Mandates for Colorado and PPO Standard Health Benefit Plan for Colorado	HCO-2004-B&S-G-HBC-01-104
Rocky Mountain Choice PPO Health Benefits Contract	HCO-2004-CHOICE/PPO-G-HBC-01-604
Rocky Mountain Health Plans Health Benefits Contract	HCO-2004-ALL-G-HBC-01-104

It appears that the Company is not in compliance with Colorado insurance law in that the "Mandatory Complaint Procedures" section of its Health Benefits Contract form is overly restrictive. The Company's Health Benefit Contract only allows its members to contact the Division of Insurance in matters relating to covered benefits. Colorado insurance law does not restrict in any way the type or subject matter of a complaint that may be referred by members to the Division for resolution. Therefore, the Company's contractual provision is not in-line with the requirements of Colorado insurance law.

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-316, C.R.S., and Regulation 6-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to comply with Colorado insurance laws.

Issue E5: Failure of the Company's forms to limit exclusions for expenses related to the AIDS illness to the same extent as other covered illnesses and conditions.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices prohibited, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108 and 10-3-1109.

Regulation 4-2-9, Concerning Non-Discriminatory Treatment of Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Related Illness By Life And Health Carriers, promulgated pursuant to Section 10-1-109, 10-1-1104.5(3)(d)(II) and 10-3-1110 C.R.S., amended effective April 1, 2000, states in part:

Section 5 Standards

O. Insurance coverage which excludes or limits coverages for expenses related to the treatment of AIDS and HIV related illness or complications of AIDS, e.g., opportunistic infection resulting from AIDS, will not be approved for use in Colorado, except to the extent that such exclusions or limitations are consistent with the exclusions or limitations applicable to other covered illnesses or conditions covered by the policy or certificate.

The Company's Health Benefits Contract states the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

C. Limitations and Exclusions

(2) General Exclusions

(o) RMHCO may, at its sole discretion, also consider any local, community standard with respect to each service in question, and inquire as to the coverage of such service by group health insurance companies and other health maintenance organizations in the Service Area. *Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with Acquired Immune Deficiency Syndrome (AIDS)*. Any other service determined by the Medical Director to be experimental or investigative is excluded. [Emphasis added.]

Form	Form Number
HCO Solo Health Benefits Contract	HCO-2004-SOLO-I-HBC-01-104

HCO Health Benefits Contract	HCO-2004-ALL-G-HBC-01-104
Rocky Mountain Choice Preferred Provider Organization Health Benefits Contract	HCO-2004-CHOICE/PPO-G-HBC-01-604
PPO Basic Health Benefit Plan without Specified Mandates for Colorado and PPO Standard Health Benefit Plan For Colorado Health Benefits Contract	HCO-2004-B&S-G-HBC-01-104

The Company's forms are not in compliance with Colorado insurance law in that the "Benefits, Limitations and Exclusions" section of its Health Benefits Contract form specifically excludes "experimental services" and defines them as "Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with Acquired Immune Deficiency Syndrome (AIDS)". While the Company's contracts do contain a generic disclaimer, the contract does not list any other medical condition or disease under its experimental services exclusions. Therefore, the Company's stated exclusion of "certain treatments" of the AIDS virus is not consistent with the exclusions of other covered illnesses or conditions.

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. and Regulation 4-2-9. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to exclude or limit coverage for AIDS and HIV related illnesses consistent with other illnesses or conditions in the policy in accordance with Colorado insurance law.

Issue E6: Failure of the Company to properly title its Basic and Standard Health Benefit Contracts.

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2004, states in part:

. . . .

3. RULES

A. 1. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market* pursuant to Section 10-16-105(7.3), C.R.S., and for use as an conversion coverage pursuant to Section 10-16-108, C.R.S.

2. Basic Plan. T*he form and content of the basic health benefit plan, as appended to this regulation, shall constitute the basic health benefit plan design* pursuant to Section 10-16-105 (7.2), C.R.S., and shall be required for use in Colorado's small group market pursuant to Section 10-16-105 (7.3), C.R.S. and as conversion coverage pursuant to Section 10-16-108, C.R.S. In addition to offering this plan basic plan design, a small group carrier may offer options pursuant to Section 10-16-105(7.2)(b)(II), C.R.S.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO)] Basic Health Benefit Plan for Colorado."

2. Each small employer carrier shall title and market the standard health benefit plan as follows: [Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO] Standard Health Benefit Plan for Colorado." [Emphases added.]

. . . .

Emergency Regulation 04-E-4, The Basic And Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective July 1, 2004, states in part:

. . . .

3. RULES

A. 1. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market* pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

2. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three design options, as appended to this regulation, and shall constitute the*

basic health benefit plan design pursuant to Section 10-16-105 (7.2), C.R.S. At least one of these three plan design options shall be required for use in Colorado's small group market pursuant to Section 10-16-105 (7.3), C.R.S. and as conversion coverage pursuant to Section 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name][*Type of plan (i.e., Indemnity, Preferred Provider or HMO)]* Basic (Health Benefit Plan without Specified Mandates, High Deductible Health Benefit Plan or High Deductible Health Benefit Plan without Specified Mandates)] for Colorado."

2. Each small employer carrier shall title and market the standard health benefit plan as follows: [Carrier name] [*Type of plan (i.e., Indemnity, Preferred Provider, or HMO*] Standard Health Benefit Plan for Colorado." [Emphases added.]

It appears the Company is not in compliance with Colorado insurance law in that its Health Benefit Contracts for the Colorado Basic and Standard plans are combined in one document as opposed to being titled separately as required by Colorado insurance law. The Company's Standard and Basic Health Benefit Plan contract also appears to be in violation of Colorado insurance law in that it fails to specify the type of plan (PPO).

Additionally, this formatting of the Colorado Basic and Standard health benefit plans is potentially confusing to the Member when attempting to determine the benefits provided to them under their contract. The Company's Health Benefits Contracts are titled as follows:

ROCKY MOUNTAIN HEALTH PLANS
STANDARD AND BASIC HEALTH BENEFIT PLANS FOR COLORADO
HEALTH BENEFITS CONTRACT
and
ROCKY MOUNTAIN HEALTH PLANS
PPO BASIC HEALTH BENEFIT PLAN WITHOUT SPECIFIED MANDATED FOR COLORADO
AND
PPO STANDARD HEALTH BENEFIT PLAN FOR COLORADO
HEALTH BENEFITS CONTRACT

Form	Form Number
Standard and Basic Health Benefit Plan	HCO-2004-B&S-G-HBC-01-104
PPO Basic Health Benefit Plan without Specified Mandates for Colorado and PPO Standard Health Benefit Plan for Colorado	HCO-2004-B&S-G-HBC-01-104

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to properly title them in accordance with Colorado insurance law.

Issue E7: Utilizing forms that inequitably represent that the Company is solely responsible for determining if medical services and/or treatments are experimental in nature.

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states in part:

> (3)(b) An evidence of coverage shall contain:
>
> (I) *No provisions or statements* which are unjust, unfair, *inequitable*, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in section 10-16-413 (1): [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that the "Benefits, Limitations and Exclusions" section of its Health Benefits Contract form inequitably represents that the Company is solely responsible for determining what medical services and/or treatments are experimental in nature. The wording of the Company's contract appears to allow the Company and its Medical Director to make determination of what is experimental treatment without consultation of the greater Medical Community as to what is generally accepted to be experimental treatment. This wording also could allow the Company to deny benefits for a treatment that it deems is experimental, which may not be considered as such by the established experts of the Medical Community.

The Company's Health Benefits Contract states the following:

> **3. BENEFITS, LIMITATIONS AND EXCLUSIONS**
>
> **C. Limitations and Exclusions**
>
> **(2) General Exclusions**
>
> *(l) Services determined by RMHCO to be experimental in nature*. Whether a service is experimental may be determined by RMHCO either before or after a Member requests that RMHCO provide such service as a Benefit. *RMHCO will determine the experimental nature of a medical service through RMHCO's medical department and the Medical Director*. RMHCO may, *in its sole discretion*, review material from or seek input from the following groups:
>
> The Food and Drug Administration
> The National Institute of Health
> The American Medical Association
>
> RMHCO may, *in its sole discretion*, also consider any local, community standard with respect to each service in question, and inquire as to the coverage of such service by group health insurance companies, and other health maintenance organizations in the Service Area. Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with the Acquired Immune Deficiency Syndrome (AIDS). *Any other service determined by the Medical Director to be experimental or investigative is excluded*. [Emphases added.]

Form	Form Number
Standard and Basic Health Benefit Contract for Colorado	HCO-2004-B&S-G-HBC-01-104
PPO Basic Health Benefit Plan without Specified Mandates for Colorado and PPO Standard Health Benefit Plan for Colorado	HCO-2004-B&S-G-HBC-01-104
Group Health Benefit Contract	HCO-2004-ALL-G-HBC-01-104
Rocky Mountain Choice PPO Health Benefits Contract	HCO-2004-CHOICE/PPO-G-HBC-01-104
SOLO Health Benefits Contract	HCO-2004-SOLO-I-HBC-01-104

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to comply with Colorado insurance law.

Issue E8: Failure, in some instances, to file and certify a new policy form in accordance with Colorado insurance law.

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states in part:

> (3) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer had filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

> (2) All sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing health care coverage authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, application, endorsement or rider at least thirty-one days before using such policy form, application, endorsement, or rider for any health coverage. Such listing shall also contain a certification by an officer of the organization that such new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer's good faith knowledge and belief, with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to Sections 10-1-109, 10-4-419, 10-4-633, 10-15-105, 10-16-107.2 and 10-16-119, C.R.S., amended effective February 1, 2004, reads in part:

Section 4. Definitions

M. "Listing of New Policy Forms for health coverage" shall mean a list of any new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado and the title of the program or product affected by the forms, and the effective date the form will be used.

Section 5. Rules

A. At least 31 days prior to using any new form (except preneed funeral contracts and

> excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" forms, which are filed concurrently) each entity, subject to the provisions of this regulation, shall file, in a format prescribed by the Commissioner, a Listing of New Policy Forms including a fully-executed certificate of compliance. Any such listing and the applicable certificate of compliance must be prepared individually for each product.

It appears the Company is not in compliance with Colorado insurance law in that the Company failed to file and certify its policy form relating to the Colorado Basic Health Benefit Plan upon modification of title and/or benefits of its policy form as required by Emergency Regulation 04-E-4. The Company states that "Although the title of the Companies' Basic plans were changed in July 2004 to comply with Emergency Regulation 04-E-4, no new policy forms were necessary at that time as a result of the changes in the law. Therefore, no form filing for new policy forms was necessary in July 2004 under Regulation 1-1-6".

The Division of Insurance respectfully disagrees with the Company's position in this regard. A revised title and/or change in benefits requires a filing of a Listing of New Policy Forms for health coverage (to include the date of usage of the form) as set-forth in Colorado insurance law, along with the required Company certification of Compliance at least thirty-one (31) days before use.

Form	Form Number
HCO Basic Health Benefit Plan without Specified Mandates for Colorado and HCO Standard Health Benefit Plan for Colorado	HCO-2004-B&S-G-HBC-01-104

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-107 and 10-16-107.2, C.R.S., and Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to file and certify new policy forms in accordance with Colorado insurance law.

Issue E9: Failure of the Company's forms to properly describe the home health care and hospice care services in accordance with Colorado insurance law.

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services and Hospice Care, promulgated pursuant to §§ 10-1-109 and 10-16-104(8)(d), C.R.S., effective February 1, 2001, states in part:

Section 4. Requirements for Home Health Services

B. General Policy Provisions Pertaining to Home Health Care.

(1) *The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization* or in place of hospitalization. Prior hospitalization shall not be required.

(2) *The policy offering shall require*, as a condition of coverage *that home health care services are to be rendered pursuant to a physician's written order, under a plan of care established by the physician in collaboration with a home health care provider*. [Emphases added.]

Section 5. Requirements for Hospice Care

A. Definitions

(6) The "interdisciplinary team" is a group of qualified individuals, which shall include, but is not limited to, a physician, registered nurse, clergy/counselors, volunteer director, and/or *trained volunteers*, and appropriate staff who collectively have expertise in meeting the special needs of hospice patient/families. [Emphasis added]

"Hospice staff" shall include *volunteers* and paid persons. [Emphasis added]

B. General Provision Pertaining to Hospice Care.

(1) *The policy offering shall provide that hospice care services are to be covered* when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, *regardless of the location or facility in which such services are furnished*.

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

(3) *The policy offering shall require a physician's certification of the patient's illness, including a prognosis for life expectancy and the appropriateness for hospice care.* The insurer may also require a copy of the patient's plan of care and any changes made to the level of care or to the plan of care.

(5) *The policy offering shall clearly indicate that services and charges incurred in connection with an unrelated illness will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.* [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that the description of home health care and hospice services contained in the Company's Health Benefits Contract does not meet the requirements of Colorado insurance law in that:

With regard to home health services, the Company's Health Benefit Contract form does not provide the required language stating that:

(1) Home health care services are required to be rendered pursuant to a physician's written order under a plan of care established with the physician and the home health care provider.

With regard to hospice care, the Company's Health Benefit Contract form does not provide the required language stating that:

(1) Hospice care services, when managed and coordinated through a hospice, are to be covered regardless of the location or facility where services are provided.

(2) Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, and that there is coverage for three benefit periods should the individual continue to live beyond the life expectancy;

(3) Charges for services incurred in connection with an illness unrelated to the condition for which hospice care is needed will be processed in accordance with policy coverage provisions applicable to all other illnesses and/or injuries.

The Company's Health Benefits Contract states in part the following:

(1) BENEFITS, LIMITATIONS AND EXCLUSIONS

Schedule of Benefits

(14) Home Health Services

Home Health Services if Preauthorized by RMHCO and rendered by a Participating Provider under the terms of a Home Health Care Plan, including:

17. DEFINITIONS AND INTERPRETATION

A. Definitions

(25) "Home Health Care Plan" means a program of home care that:

(a) is required as a result of a sickness or injury; and

(b) is certified by the Member's attending Physician as a replacement for hospital confinement that would otherwise be necessary.

(26) "Home Health Services" means intermittent skilled nursing and related Heath Care Services provided in the home of a Member under such Member's attending Physician.

(2) BENEFITS, LIMITATION AND EXCLUSIONS

Schedule of Benefits

(15) Hospice Services

Benefits: Supportive and palliative care for a Member with a life-threatening illness or injury from which a recovery is not expected and which is provided in the home of the Member or in a Hospice when approved by the Medical Director. Benefits shall be for services provided by a Hospice, Hospice Care Team, Hospital, Participating Provider of Home Health Services or Skilled Nursing Facility for:

- any sick or injured Member who, in the opinion of a Physician, has no reasonable prospect of cure; and
- the Immediate Family, primary caregiver and persons with close significant personal ties to such Member.

Form	Form Number
SOLO Health Benefits Contract	HCO-2004-SOLO-I-HBC-01-104
PPO Health Benefits Contract	HCO-CHOICE/PPO-G-HBC-01-604

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to comply with Colorado insurance law.

UNDERWRITING APPLICATIONS FINDINGS

Issue G1: Failure to obtain the required employer listing of eligible dependents.

Regulation 4-6-8, amended effective March 2, 2004, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109 and 10-16-708, C.R.S., states:

Section 5. Issuance of Coverage

B. Determining Who is an Eligible Employee, Dependent

3) A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide *a complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* [Emphasis added.] The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof.

Small Group Application Sample

Population	Sample Size	Number of Exceptions	Percentage to Sample
4,754	50	50	100%

The examiners reviewed a systematically selected sample of fifty (50) files from a population of 4,754 representing new small group applications received during the exam period of January 1 through December 31, 2004. Based on the files examined, it appears that the Company is not in compliance with Colorado Insurance law in that none of the sample files contained a list of eligible employees and dependents.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer groups complete an employer provided listing of eligible dependents as required by Colorado insurance law.

UNDERWRITING CANCELLATIONS/ NON-RENEWALS/DECLINATIONS FINDINGS

Issue H1: Failure, in some cases, to issue certificates of creditable coverage that reflect the definition of "Significant break in coverage."

Insurance Regulation 4-2-18, amended effective October 1, 2004, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3) or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation.

INDIVIDUAL CANCELLED FILE SAMPLE – Certificates of Creditable Coverage

Population	Sample Size	Number of Exceptions	Percentage to Sample
699	46	14	30%

SMALL GROUP CANCELLED FILE SAMPLE – Certificates of Creditable Coverage

Population	Sample Size	Number of Exceptions	Percentage to Sample
239	50	10	20%

The examiners reviewed a systematically selected sample of forty-six (46) files from a population of 699 representing cancellations, terminations and rescissions of individual policies during the exam period of January 1 through December 31, 2004. Originally, fifty (50) files were selected for review but four of these were not appropriate. Based on the files examined, it appears the Company is not in compliance with Colorado Insurance law in that fourteen (14) certificates of creditable coverage were issued that did not reflect the definition of "Significant break in coverage."

The examiners also reviewed a randomly selected sample of fifty (50) files from a population of 239 HCO small group policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. Based on the files examined, it appears that in ten (10) files, the Company is not in compliance with Colorado insurance law in that the certificates of creditable coverage that were

issued after October 1, 2004 did not reflect the definition of "Significant break in coverage" required by Regulation 4-2-18(5)(B)(4).

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that certificates of creditable coverage issued will contain the definition of Significant break in coverage as required by Colorado insurance law.

Issue H2: Failure to use policies and procedures in individual plan cancellations, which do not permit unfair discrimination.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;
>
> (f) (II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

CANCELLED INDIVIDUAL FILE SAMPLE – Late Terminations Request

Population	Sample Size	Number of Exceptions	Percentage to Sample
699	46	8	17%

The examiners reviewed a randomly selected sample of forty-six (46) files from a population of 699 HCO individual policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. It appears that the Company is not in compliance with Colorado insurance law in that its procedures regarding the handling of late termination requests are misleading and allow for unfair discrimination. The Company's termination policies and procedures state that retro terminations may be granted if requested by the member and agreed to by the Company. This could lead to unfair discrimination in that there are no specific guidelines regarding which types of requests should be granted and which shouldn't. Therefore, the decisions could be made inconsistently/arbitrarily, leading to unfair discrimination. Additionally, the policy is misleading in that if a specific date is requested, the policy says the date will be the date the termination form was received but this contradicts all of the sample letters provided as well as the files reviewed.

The Company's procedures "Terminations – Group and Subscriber/Member of Groups" state the following:

> POLICY: In compliance with HB1353, RMHP will not allow retro terminations.

Member Policy: Termination notification must be received by RMHP no later than 5:00 p.m. Mountain Time on the first business day of the month following the disenrollment effective date.

Notification received by Rocky Mountain Health Plans later than the first business day of the month following the disenrollment effective date will result in an extension of coverage for an additional month with the required premium.

The Group and Individual Terminations Policies and Procedures state the following (the policy contains no form number or revision date):

3. The incoming date stamp on the form determines the date of termination. Example: Termination form that is date stamped 1/06/03 would be terminated as of 1/31/03. Deadline for the termination form is the end of the day of the first business day of the month. Any termination form received after the deadline will be considered a late termination.

4. If the entire group is terminating due to replacement of their coverage with another carrier then a retro termination can be done provided the group signs an agreement to be responsible for any claims currently submitted or submitted in the future.
   a. Request proof of replacement coverage.
   b. Send claims agreement to group for signature.
   c. Retro term group. Do not bill premiums for the month.

5. Send Late Termination Letter.doc to the group if the termination date indicated on the form is for a month prior to the end of the current month.

Solo/Individual Terminations:
Solo/Individual Terminations will work the same as group terminations unless there is a particular date indicated on the termination form, if this is the case the termination date will be the date we received the termination form and premiums will be pro-rated in Billing.

The Company's "Late Termination Letter.doc" states the following:

Rocky Mountain Health plans (RMHP) is in receipt of your termination form received <<TermReceivedDate>> for <<MemberName>> to be effective <<RequestedDate>>.

In accordance with Colorado law (House Bill 02-1353), employers who sponsor health plans are obligated to pay additional premium when the group fails to provide timely notice to carriers. Consistent with the premium payment provisions of our contract with <<Company>>, Rocky Mountain Health Plans requires notice of terminations by the end of the first business day following the termination effective date.

Due to the late notification of your termination request, coverage for <<MemberName>> will be extended through <<Newtermdate>> and premium for the additional month(s) will be owed at the same coverage level as <<PreviousMonth>> for this subscriber.

The Company's letter number "EB02R0204" (no identifying title or subject) states the following:

Rocky Mountain Health Plan (RMHP) has carefully considered your request for credit regarding <<Member Name>>.

Your request has been denied, because RMHP policy is that we do not retro terminate members

from coverage. Since we were not notified prior to <<NotnotifiedpriortoDate>> and therefore may have verified this member's eligibility for health care services, RMHP is obligated by law to pay for any health care services <<MemberName>> may have received in <<Month>>.

A review of the files showed that in eight (8) instances where either a mid-month or a retro termination was requested, the Company did not grant seven (7) of these requests. There was no explanation in any of the files regarding why the requests were rejected. However, in two (2) cases where the company cancelled for nonpayment of premium, those members were terminated mid-month, without prior notification to the member of the termination.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its cancellation/termination procedures to ensure that unfair discrimination is not permitted as required by Colorado insurance law.

CLAIMS FINDINGS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*[Emphasis added.]
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of the additional information is needed to resolve the claim, including any additional medical or other information related to the claim…

CLEAN ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
23,170*	100	77	77%

(*6% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 23,170 claims that had not been paid, denied or settled within thirty (30) days. It appears the Company is not in compliance with Colorado law in that:

Seventy-nine (77) of the electronic claims in the sample appear to represent clean claims but were not paid, denied, or settled within thirty (30) days.

CLEAN PAPER CLAIMS PROCESSED OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
8,425	100	61	61%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 paper claims from a total summarized population of 8,425 claims that had not been paid, denied or settled within forty-five (45) days. It appears that the Company is not in compliance with Colorado insurance law in that sixty-one (61) of the claims reviewed appear to represent clean claims, but were not paid, denied, or settled within forty-five (45) days. The examiners note that many of the claim numbers selected for review represented adjustments made to original claims. In these cases the examiner reviewed the original claim as well as the adjusted claim and the reason for the adjustment. In some instances the examiners determined that the original claim was a clean claim and therefore the adjusted claim did not appear to be properly paid, denied or settled within the required timeframe.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,758*	50	33	66%

(*<1% of all paid and denied claims)

It appears the Company is not in compliance with Colorado insurance law in that it failed to pay, deny or settle thirty-three (33) of the fifty (50) claims within the required ninety (90) days. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) days of receipt.

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> . . . .
>
> (c) *Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.* [Emphasis added.]
>
> . . . .
>
> (5) (a) *A carrier that fails to pay, deny or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphasis added.]
>
> (b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphasis added.]

CLEAN CLAIMS PROCESSED OVER 30 DAYS—PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
23,170*	100	24	24%

(*6% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 23,170 claims that had not been paid, denied or settled within thirty (30) days. It appears that the Company is not in compliant with Colorado insurance law in that it failed to pay interest on twenty-four clean, electronic claims that were not adjudicated within the required time-frames. The twenty-four (24) claims identified required payment of interest and these monies were not paid to either the provider or, in the case of incorrect co-pay/co-insurance being collected by the Company, the insured.

CLEAN CLAIMS PROCESSED OVER 45 DAYS—PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
8,425*	100	53	53%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 paper claims from a total summarized population of 8,425 claims that had not been paid, denied or settled within forty-five (45) days. It appears that the Company is not in compliance with Colorado insurance law in that of the fifty-three (53) paper claims that were not paid, denied, or settled within forty-five (45) days where interest was determined to be due:

- Thirty-three (33) claims appeared to be clean claims, but no interest was paid; and
- Twenty (20) claims appeared to be clean claims but the amount of interest paid was incorrect.

CLAIMS OVER 90 DAYS—PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,758*	50	45	90%

(*<1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 50 claims from a total summarized population of 3,758 claims that had not been paid, denied or settled within ninety (90) days. It appears that the Company is not in compliance with Colorado insurance law in that the Company failed to pay a ten (10) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day on each of the forty-five (45) claims not paid or settled within ninety (90) days.

The examiners note that many of the claim numbers selected for review represented adjustments made to original claims. In these cases the examiner reviewed the original claim as well as the adjusted claim and the reason for the adjustment. In some instances the examiners determined that the original claim was a clean claim and therefore the adjusted claim did not appear to be properly paid, denied or settled within the required timeframe and interest was due.

Additionally, it appears that in many instances the claim reviewed had been updated by a Company representative to show a different "interest clean" date. The examiners were unable to locate documentation to substantiate these updated dates. The dates do not appear to correspond to any particular event or the date the claim was ultimately processed and paid. It does not appear that the Company's staff is applying the above-cited procedure consistently or appropriately, resulting in inaccurate interest payments and a possible violation of Colorado insurance law.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that, except where fraud is involved, all claims are paid, denied, or settled within required time frames and that a penalty is paid on those claims not processed within such frames as required by Colorado insurance law. The Company should also be required to perform a self-audit to identify and pay any interest and/or penalties due on all claims that were not paid or settled within the required time periods from January 1, 2004 through the date of the Final Agency Order.

Issue J3: Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
44,856	100	14	14%

From a population of 44,856 denied claims received from January 1, 2004, through December 31, 2004, a randomly selected a sample of 100 denied claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time the claims were denied, it appears that the Company either:

- was in possession of the information it needed to properly adjudicate the claims; or
- it failed to request required additional information.

It appears that this resulted in unfair and inconsistent treatment of members as follows:

- One (1) claim (Comment J4) was incorrectly denied for other insurance;
- One (1) claim (Comment J6) was improperly denied due to an inappropriate modifier;
- Four (4) claims (Comment J8) were incorrectly denied for pre-existing conditions; and
- Eight (8) claims (Comment J11) were incorrectly denied for third party liability.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that its processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims to assure compliance with Colorado insurance law.

Issue J4: Failure to use claim payment procedures that do not result in unnecessary delays.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or
>
> (VI) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-106.5(4), C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Regulation 4-2-24, effective February 1, 2003, Concerning Clean Claim Requirements for Health Carriers, and promulgated under the authority of 10-16-106.3(2), 10-16-109, and 10-1-109, Colorado Revised Statutes, states:

> Section 6 Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate the claim. *Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made.* When additional information is required, the carrier shall make *the specific request in writing* within thirty calendar days after receipt of the claim form. *If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim.* The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request. [Emphases added].

B. *Additional information requested must be related to information in the required fields of the claim forms*, [emphasis added] although the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in a required field is incorrect such as previous claims that indicate the treatment was for work-related injuries when the claim form indicates otherwise. Requests for additional information to determine if the treatment is medically necessary or if a pre-existing condition limitation applies would be related to the fields specifying the services provided.

C. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all required fields correctly completed and the services were preauthorized pursuant to 10-16-704(4), C.R.S.

D. *When all additional information or documentation necessary to resolve the claim is provided with the appropriate claim form that includes all required elements as specified in Section 5 of this regulation, the claim shall be considered a clean claim and processed within the timeframes specified in statute.* [Emphasis added.] The following circumstances are those for which additional information is generally required by most health carriers:

   i. When the coverage is not primary, an EOB from the primary payer;
   ii. When service/procedure codes indicate "unusual" procedural services or anesthesia, the medical records to justify medical necessity;
   iii. When surgical procedures utilize multiple surgeons, the medical records to justify medical necessity;
   iv. When the procedure is a repeat procedure, the medical records to justify medical necessity;
   v. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and
   vi. When services are billed using a "by report" or unlisted CPT code, medical records to substantiate the claim.

D. *If a managed care plan requires medical or other records on all claims for particular types of services/procedures or diagnosis codes, the carrier must clearly disclose such requirements in the provider contract, provider manual, or provider manual updates*. [Emphasis added.] If a carrier contracts with an intermediary, the carrier shall be responsible for making sure the intermediary provides such disclosure to contracted providers in a timely manner.

F. When requesting medical records, carriers must identify the particular component(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. Requests for "all medical records" is not specific enough and would not be an appropriate request for claim adjudication. Medical information requested from institutional providers shall be additionally limited to the following:

i. History and physical reports;
ii Consultant reports;
iii. "Op" reports;
iv. Discharge summaries;
v. Emergency department reports;
vi. Diagnostic reports; and
vii. Progress reports.

The Company's Claim Medical Processing Manual – Third Party Processing, revised March of 2005, states on page 4:

> Third Party Liability (TPL) injury information that relates to claims that fit the TPL criteria is stored in the Rocky Interface database. *All claims that meet TPL criteria will pend for possible Third Party Liability Review.* [Emphasis added].

On page 7:

> **Financial Recovery List of Diagnosis Codes**
>
> The diagnosis lists are configured for the RMHP Financial Recovery Team to research claims for potential third party liability.
>
> Effective 04/05/04: TPL Diagnosis List *
>
> *Examiner Note – this is a hyperlink to an Excel spreadsheet containing 1173 diagnosis codes.

On page 24:

> **TPL Investigation**
>
> The TPL Team investigates claims using criteria related to the TPL diagnosis, dollar amount or known Third Party Liability. Warning messages and member notes are set up so that the Claims Examiner will be made aware of when these claims should be pended.

Investigation Process

- One *phone call* should be made to the member. [Emphasis added].
- If the member does not respond, a letter will be sent within 48 hours after the initial message was left.
- Written request for information shall be mailed within 30 days of the date the claim was submitted.
- The letter should request that the information be returned within two weeks from the date the letter was generated. Claims will not be denied R61 until 30 days after the letter was generated.
- Commercial, Individual, and Medicaid: If the member does not respond by 30 days, related claims will be process using R61 claim denied because

On page 28:

COB/TPL Macess & Facets Workflow

TP32 Workflow

The TPL Interface (pre-Facets) assigns pend code TP32 when the following occurs:

- The billed diagnosis has been defined within configuration (A warning message may be attached that states ***Possible Third Party/Pend if line item is great than $300.00***.)

On page 38:

TP60 Workflow

Review all claims aged 30 days or greater, from the date the letter was sent, by comparing information in the TPL interface to the diagnosis on the claim. Once this is complete claims need to be denied, pended or paid in Facets.

TPL Interface

- If the information is complete the notes will state this or the type of injury will state "No COB". The pend reason CB60 should be noted in the memo field of the claim.
- If the injury\illness is still in the research process, meaning a letter has been sent but 30 days have not passed or the claim has not aged 80 days, the claim should remain in TP60. If the 30 days have passed or the claim is older than 80 days the claim should be denied allowing $0.00 and using the explanation code R61.

On page 46:

RMHP – PRIMARY FOR ALL LOB

Line of Business	Scenario	Worker's Comp	Auto and No Fault	Auto and Tort System	Liability – Homeowners	Liability – Med Pay
Private Pay	Information in database, notes indicate Other Party Primary	Deny Claim – R63	Deny Claim – R62	Med-pay or underinsured/ uninsured motorist available deny R62: Otherwise Pay Claim & Pursue	Pay Claim & Pursue	Pay Claim & Pursue
Private Pay	No information in database, notes don't indicate Other Party Primary. Send letter to member, if no response within 30 days	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61

The form letter (no document number or revision date available for this form) used by the Company to investigate third party liability claims states on page 1:

> …To help keep health care premiums down, we research claims to find out if another insurance carrier or a person or a business may be responsible for payment. This research also helps you get the medical coverage your plan provides as soon as possible.
>
> Please answer **all** the questions below. Write with **BLACK INK** only. Then return this letter in the enclosed envelope **within 20 days of the date of this letter**. Without this information, payment of these claims could be *delayed, or you may have to pay for the cost of the care yourself.* [Emphasis added].
>
> Date of original accident/injury/illness: _____
>
> Was the injury the result of any illness? YES NO
>
> Was the injury the result of any accident? YES NO
>
> Was the injury the result of an automobile accident? YES NO
> If yes, please provide RMHP with a complete copy of your auto policy.
>
> Was the injury the result of loading/unloading/exiting or entering vehicle? YES NO
> If yes, please provide RMHP with a complete copy of your auto policy.

Was the injury the result of maintenance on your vehicle? If yes, please provide RMHP with a complete copy of your auto policy.	YES	NO
Was or does your work contribute to your condition?	YES	NO

The examiners reviewed the Company's Third Party Liability claim handling procedures. Adherence to these procedures may result in a violation(s) of Colorado insurance law. These procedures require that additional information be requested on all claims over a certain dollar amount and containing certain

diagnosis codes. It appears that the Company is ignoring the accident information fields on the initial claim form and instead requesting the information again via the above-cited TPL form letter. Requests for additional information to determine liability should be specific to the information necessary for the Company to determine its liability, and should not include questions regarding unrelated information or information already provided on the provider's claim form. Also, it appears that the mailing of this letter is preceded by a phone call to the member. All requests for additional information necessary to process a claim must occur in writing.

Additionally, it does not appear that the provider is being copied on, or advised of, the additional information request. Finally, the examiners were unable to locate any documentation that the Company had advised their contracted providers either via provider contract, provider manual, or provider manual update that these records would be required on all claims for particular diagnosis codes. It appears that application of these procedures may result in unnecessary claim payment delays.

Recommendation No. 16

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. and Regulation 4-2-24. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its claim payment procedures to limit requests for additional information to only those instances in which additional information is necessary for the Company to determine its liability, to ensure compliance with Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to include all required elements in written notification letters sent to members and providers regarding appeals.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain* [emphasis added]:

a. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposes of the section, the physician and the consulting clinical peers shall be called "the reviewers");

e. A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

E. (1) First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

I. The decision issued pursuant to Subsection G shall set forth in a manner calculated to be understood by the covered person:

(1) The name, title The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers.");

J. A first level review decision involving an adverse determination issued pursuant to Subsection G shall include, in addition to the requirements of Subsection I:

LEVEL 1 APPEALS – Reviewer's Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
38	38	34	90%

LEVEL 1 APPEALS – Peer's Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
38	38	28	74%

The examiners reviewed the entire population of thirty-eight (38) HMO utilization review first level appeals files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained appeal requests that were received prior to April 1, 2004 and therefore were subject to the April 1, 2000 version of amended Regulation 4-2-17. It appears that the Company did not meet the requirements of Colorado insurance law in that in its written determination notices sent to the provider and the member did not contain all required elements.

- In thirty-four (34) of the files, the name, title, and/or credentials of the physician evaluating the appeal were not documented on the written notifications; and

- In twenty-eight (28) of the files, the credentials of the clinical peer(s), with whom the evaluating physician consulted, were not documented on the written notification.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that its written notification letters regarding appeals, contain all elements as required by Colorado insurance law.

Issue K2: Failure, in some instances, to make utilization review approval determinations or to notify the member and provider of the determination in the manner and time frame allowed by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states in part:

> Section 6. Procedures for Review Decisions
>
> B. For prospective review determinations, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination.
>
> 1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and/or the provider within two (2) working days of making the initial certification
>
> C 1) For concurrent review determinations, a health carrier shall make the determination within one (1) working day of obtaining all necessary information.
>
> 2) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification. The written or electronic notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.
>
> D. For retrospective review determinations, a health carrier shall make the determination within thirty (30) working days of receiving all necessary information.
>
> 1) In the case of a certification, the carrier shall notify in writing the covered person and the provider rendering the service within five (5) working days of making the determination to provide coverage.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 6. Standard Utilization Review

A A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.

B. (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.

C. (1) (a) For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request.

UR APPROVALS – Phone Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	15	15%

UR APPROVALS – Written Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	14	14%

UR APPROVALS – Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	23	23%

The examiners reviewed a randomly selected sample of 100 files from a population of 5,609 HMO utilization review (UR) approvals requested during the examination period of January 1, 2004 to December 31, 2004. Twenty-two (22) of the files contained UR requests that occurred prior to April 1, 2004 and therefore were subject to the April 1, 2000 version of Regulation 4-2-17. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In fifteen (15) of the files with request dates prior to April 1, 2004, phone notification was not provided;
- In fourteen (14) of the files with request dates prior to April 1, 2004, written notice was not provided; and
- In twenty-three (23) of the files with request dates on or after April 1, 2004, the provider and the covered person were not notified of the determination.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review approval procedures to ensure that utilization review determinations are made and communicated in the proper manner and within the time frame required to ensure compliance with Colorado insurance law.

Issue K3: Failure, in some instances, to provide written notification of adverse utilization review denials or to provide the notifications within the time frames required by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

Section 6. Procedures for Review Decisions

(B) (2) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.

(C) (3) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation to the covered person and the provider within one (1) working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination.

(D) (2) In the case of an adverse determination, the carrier shall notify in writing the provider rendering the service and the covered person within five (5) working days of making the adverse determination.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 6. Standard Utilization Review

(B) (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.

(ii) Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.

(E) (1) A notification of an adverse determination under this section shall, in a manner set calculated to be understood by the covered person, set forth:

(2) A health carrier must provide the notice required under this section in writing, either on paper or electronically.

Section 7. Expedited Utilization Review

(B) (1) (a) For an urgent care request, unless the covered person has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person and the covered person's provider of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the health carrier.

(b) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

(D) For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(E) (2) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.

(b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

UR DENIALS – Written Notification Not Provided

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	50	7	14%

The examiners reviewed a randomly selected sample of fifty (50) out of a population of ninety-six (96) HMO utilization review denial files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained UR request dates prior to April 1, 2004 and therefore these files were subject to the April 1, 2000 version of the regulation. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In one (1) of the files with a request date prior to April 1, 2004, no written notification was provided;
- In two (2) of the files with request dates prior to April 1, 2004, the written notification was not sent to both the member and provider;
- In two (2) of the files with request dates on or after April 1, 2004, the written notification was not sent to both the member and provider; and

- In two (2) of the files with request dates on or after April 1, 2004, the written notification was not sent with in the required timeframe.

Recommendation No. 19

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notifications of utilization review denials are sent within the appropriate timeframe and to all mandated individuals as required by Colorado insurance law.

Issue K4: Failure, in some instances, to include all required elements in written notifications of utilization review denials sent to members and providers.

Regulation 4-2-17(VI), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Procedures For Review Decisions, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

> E. *A written notification of an adverse determination shall include* the principal reasons for the determination, the *instructions for initiating an appeal* or reconsideration of the determination, *including expedited appeals*, and the *instructions for requesting a written statement of the clinical rationale, including the clinical criteria used to make the determination*, to any party who received notice of the adverse determination and who follows the procedures for a request. *A carrier shall specify that such an appeal process shall include a two-level internal review*, except as provided for in section 8.I.A.5 of this regulation. [Emphases added.]

Regulation 4-2-17(VI), amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, Standard Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

> E. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
>
> (a) An explanation of the specific medical basis for the adverse determination;
>
> (b) The specific reason or reasons for the adverse determination;
>
> (c) Reference to the specific plan provisions on which the determination is based;
>
> (d) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
>
> (e) *If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;* [Emphasis added.]
>
> (f) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit

plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(g) *If applicable, instructions for requesting:*

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (e) of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (f) of this paragraph; and [Emphasis added.]

(h) *A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;* [Emphasis added.]

(2) *A health carrier must provide the notice required under this section in writing, either on paper or electronically.* [Emphasis added.]

UR DENIALS – Written Notice Information

Population	Sample Size	Number of Exceptions	Percentage to Sample
96	50	17	34%

The examiners reviewed a randomly selected sample of fifty (50) out of a population of ninety-six (96) HMO utilization review denial files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained UR request dates prior to April 1, 2004 and therefore these files were subject to the April 1, 2000 version of the regulation. It appears that the Company did not meet the requirements of Colorado insurance law in that its written determination notices sent to the member and/or provider did not include all required items.

- In five (5) of the eleven (11) files subject to the April 1, 2000 version of the regulation, the written notification did not include information on the two-level internal appeals process;
- In two (2) of the eleven (11) files subject to the April 1, 2000 version of the regulation, the written notice did not include expedited appeal instructions;
- In six (6) of the files the written notice did not include the instructions for requesting the protocol or clinical rationale used in making the determination; and
- In four (4) of the files the written notice did not include instructions on how to request the internal guidelines or similar criteria used in making the determination.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notification of utilization review denials include all necessary elements as required by Colorado insurance law.

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